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Sexual Identity in the Ghetto

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ABSTRACT: The more things change, the worse they get.

Nathan McCall's recent "Dispatches from a Dying Generation" (1991) updated Ashmore's "In my Neighborhood An Adult is a Dead Child" (1966). While Ashmore pessimism contributed to my earlier "catastrophizing," McCall's current observations on the escalation of black-on-black carnage and the anomic extension of violence into the black middle class demonstrate the understatement of my earlier social-psychiatric pessimism. I wrote then (1974):

> The existing miseries of the inner cities, I am increasingly convinced, are nurturing severe psychopathological neurotic character disorders. The defensiveness of ghetto children against caring for others, the depersonalization of their relationships, and their sadomasochistic resolutions of hurt and despair appear to prepare them for retaliation against their own communities with a potential for indiscriminate destructiveness of themselves or others. As our new generation of disadvantaged blacks assimilates its ghetto education, and as it comes of age, I would revise Kardiner's [WW II] prediction, and question whether we will not see new forms of pathology that synthesize atypical neurotic configurations with that outward seeking for trauma that Fenichel described as the "traumatophilic neurosis."

McCall noted that *the* work ethic developed all too well in the street's drug trade, that the ghetto's mutation of street capitalism en-

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hanced entrepreneurial marketing of ever more addictive and deadly street drugs with an escalation of violence, murder, incarcerations and futility. His projections are all too reminiscent: ". . . I see a younger, meaner generation out there now—more lost and alienated than we were—and placing even less value on life . . . [and] totally estranged from the black mainstream."

Courtland Milloy (1991), in his editorial review of McCall's "Dispatches," is perhaps more ready to conjecture that such catastrophic wounds derive from guilt, shame, fear and convictions of inferiority; that blacks have relieved the Ku Klux Klan of its mission to keep those in place who have not already been killed; and that rage turned against the self requires an *accumulative* programming of the "black psyche" over the span of generations. Psychoanalysis should only disagree with the last notion—*one* generation of damaged children is quite sufficient. With Ashmore, we should accept that in his neighborhood an adult was a dead child who necessarily nurtured the next generation from the perspective of his/her own devastating experience.

In this context, psychoanalysis has three strikingly clear and unambiguous limitations—and one remarkable saving grace. As to its limitations: first, as a clinical resource, psychoanalysis is simply unavailable to the impoverished black (or white) irrespective of diagnostic need. Not incidentally, even Medicaid options for the indigent discriminate institutionally and pharmacologically against psychotherapeutic care (generally). Second, clinical and theoretical parochialism have left psychoanalysis with a diagnostic nosology that is more descriptive than dynamic (Wegrocki, 1939 and Devereux, 1970). Psychoanalysts are not totally ignorant or wanting either in trans-cultural conceptualization (Devereux, 1956; Doi, 1962; Caudill and Doi, 1966) or in empirical, clinical experience. Yet institutional preconceptions about "un-treatable" psychopathology have tended to coincide with the symptoms of the lower-class black. Psychoanalysts characteristically, individually disclaim racist notions. Yet in ignoring trans-cultural psychoanalytic and military/traumatic psychiatry (Meers, 1980), our diagnostic conceptions continue flawed by a combination of ignorance and bias that Thomas and Sillen (1972) clearly understood. Third, and most relevant to our national miseries, psychoanalysts have failed in their human responsibility of making explicit to the nation the enormity of the psychiatric consequences that derive from discrimination in our society.

Smallpox was eradicated not by treating its victims, but by compre-

hending its etiology and mode of transmission. While clinical psychoanalysis can make only the most meager of contributions to relieving individual psychiatric distress in the ghetto, its socially redeeming virtue derives from the clinically unique option to intensively study and research the most subtle and intimate of psychological issues. Psychoanalytic findings can provide data of epidemiological relevance to the reduction of psychopathology, including unconscious rage turned against oneself, ones family and community (Gyomroi, 1963; Rainwater, 1966; Coles, 1968).

In the promised land, Claude Brown demonstrated that children can sometimes tell it like it really is—if they have a spokesman. I've been persuaded to synthesize and update clinical experience that can best be presented from Naomi's and Virgil's perspectives. They were separately referred during a three year observational study (Meers, 1970) of nominal retardation of first grade and kindergarten children (in a school directly across the street from my hospital and office). I had asked teachers to nominate two academically "retarded" children who I might take into exploratory, psychoanalytic treatment. They chose Naomi and later Virgil, as representative of youngsters already impaired as they entered elementary school. These two children lived within extended, three generation families that proved to be studies in both group and individual sorrow and psychopathology. They begrudgingly introduced me to the extraordinary problems of sexual identity in the black ghetto (Meers, 1969).

Repeating the first grade because of her manifest retardation and immaturity, Naomi tested with a verbal IQ of 76. Her teacher did not view either Naomi's retardation or class room retreat into fantasy as psychological symptoms. I was introduced to Naomi's mother, Mrs. N, by her teacher (a kind, very large and effectively controlling black woman), as offering a special opportunity for help. Naomi's mother spoke to me indirectly, replying to my questions through the teacher (whom she had known for years). Mrs. N was far more concerned that I should see her eldest son, Jude, whose sadistic, murderous character she convincingly documented.

Though a high school drop-out, Mrs. N was intuitively more psychological than her daughter's teacher. Naomi wasn't so dumb, Mrs. N noted. With a curious sense of shame and pride, she asked the teacher, in our introductory conference, if she had seen Naomi's "stripes" where the mother had "cut her up?" When the teacher said no, Naomi's mother continued: "Well, I'd had to give her a whupping, and she *was* cut up. That night, Naomi said she had showed you her

cuts [not true] and then she told me that extension [electrical] cords were for whupping animals, not people. She's right, of course! I shouldn't have done it." Mrs. N made it clear that Naomi quite upset her own fragile psychological integrity by "stupid lies" (patent fantasies), stubborn provocativeness and episodic, prolonged psychological withdrawals. Mrs. N. ended our first consultation commenting that she sometimes feared that in her evil rages with Naomi that she might kill her. She added, whimsically, that perhaps I might just save her life.

Mrs. N had a keen appreciation for the power of psychological conviction. At a later time, she reflected with abashed amusement on having cured Jude's bed wetting that had continued unabated into adolescence. Responsive to my eyebrows (that I certainly raised because I don't have such curative powers), she continued, noting (again) that she shouldn't have done it, that her sister had later told her it wasn't right; yet it *had* worked! Mrs. N had concluded that the only way her son would believe her would be if she convinced herself first, so she worked on her own self-conviction. When suitably persuaded, the mother went to the boys' room, butcher knife in hand, and had found Jude soaked as usual. With a voice of doom, she then made the pronouncement that if he wet once more, he could be certain that he would never pee in his bed again. She promised to cut off his "taddy-wac" and hang it on the end of the bed where it could pee on the floor but never again on the sheets. (The credibility of this threat increased with my understanding of Mrs. N's pathology.)

Naomi eventually boasted that she only wet the bed infrequently, unlike the five of her six brothers who continued chronically. She was indifferent to the fact that she suffered from chronic asthmatic attacks, like her mother and eldest brother (whose asthma became incapacitating during his worst rages). Naomi was incidentally subject to nighttime nosebleeds following tempers with her mother and she was chronically flatulent, with acute stomach aches that suggested an undiagnosed functional colitis. Naomi not only regressed into fantasy at school, at the expense of class participation, but proved remarkably inattentive to her safety even in the general environment. During the four years that I treated Naomi, she and a younger brother were each hit by cars on the street. In that context, Mrs. N advised that Naomi reminded her of her own "tuning-out", of her depressive retreat from reality. It particularly pained this mother that she experienced less compassion for Naomi, that she furiously agonized and grieved because she could not protect her daughter from a fate like her own.

Mrs. N concluded (as I did) that much of her children's difficulties had followed separations when they had been variously divided between and cared for by relatives or foster homes during her twelve pregnancies and later psychiatric hospitalizations. Mrs. N had an abiding sorrow about separations and I was sometimes uncertain whether Naomi's anxieties were original or a reflection of her mother's. For instance, during the first break in therapy I had taken a ten day Christmas vacation. Naomi's mother telephone me at home to ask that I speak to Naomi. She advised that Naomi had dreamed so realistically that I had been violently murdered that Naomi was inconsolable (which was certainly *not* evident when the child spoke with me).

Mrs. N had been given in early infancy to relatives in another state and had grown up with an enduring sense of humiliation and worthlessness. Even her first name (given to her by her mother) had been discarded and her understanding of her status evolved from her older male cousin's bullying and sexually exploitation of her throughout childhood. Mrs. N would certainly have understood *The Color Purple.*

Married at 19, Mrs. N had two children before her first husband was arrested and convicted of murder. Divorced while he served seven of his 30-year sentence, Mrs. N belatedly discovered that her second husband was a sadistic alcoholic whose paranoid convictions led him to beat her whenever he concluded that she enjoyed passing comments of other men. With twelve pregnancies (of which four miscarried and a fifth tubal pregnancy was surgically terminated), at the birth of her last baby Mrs. N had her remaining Fallopian tube tied. Acknowledging the ambivalence of her own sexuality, Mrs. N joked that even without tubes it would be just her luck to get pregnant again.

Following her last baby's delivery and her husband's continued beatings, Mrs. N became obsessed with the conviction that her only salvation would be to kill him. A fundamentalist in her religion, praying for divine intervention to stay her hand, she walked out of the house to buy menstrual pads and woke eleven days later in a public park with a total amnesia. Psychiatric hospitalization lasted over a year, with the children first institutionalized then separately placed in foster homes.

During that first psychiatric hospitalization, two of the youngest children lost their speech and Mrs. N's baby became a failure-to-thrive child; he was still tiny, an anal prober, and just beginning to talk at age three when I first met the family. Mrs. N's next oldest

child had become, she thought, "queer" (as in homosexual) wanting to be like her, seemingly (as I understood) in a defensive identification (that she severely disparaged with ridicule). Each and every one of the seven children clearly evidenced profound psychiatric distress, and each was known to one or more of my hospital's allergy, speech and well-baby clinics—without any psychiatric referrals, ever.

My child, ghetto patients' analyses began and continued, to my surprise, quite like middle-class, latency age children. Naomi's sense of her problem(s) was limited to her conviction of being impossibly stupid. She could not work systematically to master simple subjects such as the alphabet or number sequences. Yet, incongruously, she was immediately competent with the complexities of my office's multi-button telephone system, a complicated air conditioner, and the combination of my briefcase lock. Much of her nonacademic learning was spontaneous and persisting. Naomi could readily recall the contents of my desk, including things that I had quite forgotten. Her recall was selectively, episodically excellent, yet alternately, selectively, grossly faulty. She was intensely sensitive about failure and would rather not know, and say she didn't care, than to make an effort and discover or hear that she was wrong. Her memory of names was particularly unpredictable, including mine and my secretary's. Indeed, I was stunned when Naomi could not remember her mother's name when (with my help) she called the hospital to ask for her mother's room telephone number. Not incidentally, that was the first of the three times that Mrs. N was psychiatrically institutionalized while I saw Naomi.

Naomi sustained brief and tenuous passions for learning that were more magical than real. Regressing more often into a type of talk and play that were dramatically infantile, Naomi gave the clear impression that she was more secure in ignorance. Fantasy seemed a more pleasant refuge, and Naomi noted that Peter Pan did not have to grow up and didn't have to go to school. Learning carried a burden, as when a more competent child merited even less of a distraught mother's free time.

While Naomi showed little discomfort about her own disheveled appearance and incidental dirtiness, she was inconsistently compulsive in her fear of germs. At times she would not use her tongue to lick and seal an envelope; yet incongruously, she might lick candy directly off the floor. Her conduct in therapy often involved obsessive cleaning, particularly correcting, erasing, redoing her own mistakes in printing and drawings. Her obsessive-compulsive undoing, erasing

over and over, paralleled her embarrassed concerns for her flatulence and repetitious trips to the toilet in the first year of her therapy.

Open sexuality permeated Naomi's treatment material, and in this respect she varied dramatically from middle-class children. From her first diagnostic consultation, Naomi advised that play with a boy involves sexual passivity, but only until "he tries to put his dick in your pussy"—at which time a girl should hit him.

The first evidence of distorting sexualization of ego functions came when Naomi, looking for pencils in my desk, found a wood screw and picked it up, asking: "What's this nail doing here?" When I perplexedly repeated the word *nail?*, she replied with an annoyed expression: "Yeah, that's what I said! What's it doing here?" I noted that the nail was usually called a *screw*—and Naomi's face flushed as she murmured something indistinct. Clarification continued over months of work in documenting that Naomi's sexualized associations left her with severe inhibitions in her recall of particular words, synonyms and even some individual letters of the alphabet. *Screw* was a synonym for *chicken-butt* (intercourse), *but* (the grammatical conjunctive) equaled *butt* (bottom), *kitty* and *cookie* equaled *pussy* (vulva). Yet Naomi was neither disingenuous nor ignorant. She knew that all too many words left her confused, that she sensed other words as ambiguous and her understanding marginally embarrassed. She felt humiliated by her incapacity to even understand her own error when it was reflected back to her. My appreciation for her sense of stupidity grew with my understanding of how miserable she felt when she became confused or embarrassed with words that she somehow knew yet could not understand.

Periodically, and over time, Naomi worked at her alphabet, eventually contrasting her established ability to remember names of most people, most things, and most of the time, with her chronic frustration that all too often she could not even remember some of the names of just twenty six letters of the alphabet, particularly the letter *J*. In her ambivalent envy of her six brothers, Naomi became increasingly open and competitive in her jokes and drawings. She spoke Chinese as a nonsense language when she intended to keep me involved yet feared that I might understand too much. Naomi accompanied her repetitious drawing of Chinese girls with a suggestive innuendo that became her joke, namely, that Chinese girls were different and wore kimonos so that no one would know. She eventually elucidated that kimonos concealed Chinese taddy-wacs. As Naomi educated me, she explained most seriously "that's why I don't like the letter *J*." I must

have conveyed my lack of understanding in my facial expression, because Naomi gratuitously advised that I was a dummy! and that a *J* (which she then printed on her drawing) was like a taddy-wac. Naomi's spontaneous use of a letter (that she had phobicly avoided and had never previously been able to print), impressed her as much as it did me.

Naomi's diagnostic psychological tests had suggested sexual trauma, probably relating to fellatio. Increasingly open in therapy, she gradually revealed that she was sexually preoccupied, often overstimulated by playing "chicken-butt" (intercourse) with one or the other of her brothers.

On her return to therapy from her (second) summer break, Naomi was strangely intimate and sorrowful with me. Her continuity was fragmented and her exaggerations patently defensive. With only five minutes remaining in that hour, Naomi spoke of a fight that she had with a bigger girl, how she had taught her a lesson and beaten her pretty badly. Volunteering that she had suffered just a little herself, Naomi raised her skirt to reveal a row of thick, striped, parallel scabs each about ¼ inch wide and two to four inches in length—some eight or nine in number—just below her buttocks. She had suffered a terrible beating.

I sadly reminded Naomi that she and I had once talked about her mother's craziness, when she had beaten Naomi before we met—and that her mother had asked if I might help Naomi to better protect herself when her mother couldn't. Slightly whimsical and *very* sadly, Naomi sighed and replied "It *was* my mother, not a big girl. She missed us when we were away in camp [a fact] and she only did it 'cause she loved me.'" Mrs. N later elaborated that she had discovered Naomi and an older brother simulating intercourse; the beating was to protect Naomi from the incest Mrs. N had not escaped. It was in this context that Naomi first asked her mother if "girl blow-jobs" were any more acceptable—and first told her mother of her introduction to cunnilingus in her foster home at age four.

It was probably two years before Naomi trusted me sufficiently to let me know that her father, whom her mother had protected from murder by her psychotic break, was a continuing, transient resident of the household. His presence was denied publicly to protect the family's welfare eligibility. At the time I merely marveled that Mrs. N was either extraordinarily generous, or grievously, masochistically afflicted, or both.

Sometimes Naomi would proudly echo, in the same breath, her

mother's family legend that she, Naomi, had never sucked her thumb *and* was (toilet) trained before she was one-year-old. While Naomi's recurring toilet needs and flatulence clearly troubled her, she reveled exhibitionistically in her orality. With lolly pops, candy canes and coke bottles, Naomi kissed, licked, tongued, and sucked hungrily, humorously and erotically. I was surprised that Naomi had sufficient money for cokes and candy that she brought to my office, and more surprised to learn eventually that it was given to her by Jude (whose sadism worried Mrs. N).

Whatever her mother's apprehensions, Naomi did not appear frightened of her brother. I was then impressed that Jude's stability and presence during the episodes when their mother was hospitalized or unavailable had left Naomi dependently seducible. I gradually learned that Naomi had been fellating Jude on demand since about age six. As her psychological work enhanced her sense of self protection, and as her understanding that her brother's incestuous demands were an invitation to their mother's murderous potentials, Naomi withdrew from such sexual service. I was reasonably certain that her brother was also troubled that I had become an uncertain witness.

The children were all superstitious. One of Naomi's older brothers annoyed Jude by shooting a small metal clip (a fastener from their mother's brassier) with a rubber band—and he accidentally hit the eldest in the eye. The hospital emergency room medicated Jude's eye that night, then made a profound error in sending the boy home. In the early hours of the following morning, Naomi's brother woke in severe pain to discover that his injured eye was horribly swollen and his uninjured eye also bloodshot. The day after, when Naomi told me Jude had lost one eye in surgery, she murmured something about an eye for an eye—hinting at notions of divine justice that she would not elaborate. Jude (the furious, sadistic Jude) was most curiously, indeed pathologically docile and uncomplaining with the brother who had irrevocably damaged him.

Despite the beatings she suffered for her mother's discovery of her sexual play with her brothers, Naomi intuitively protected her eldest from their mother's potential fury. While Naomi was in treatment, I speculated that her protectiveness was altruistic. When Naomi came to see me much later in adolescence, it was specifically to inquire about her genital anesthesia in her sexual experience with a young man she loved. Naomi asked whether her adolescent/adult sexual unresponsiveness might derive from her earlier, clinical failure to be totally honest with me. In childhood she had felt so miserably

ashamed of her father that she had found herself unable/unwilling to tell me of his intrusive, drunken demands that she fellate him, which she had continued even after her brother had stopped. In that context I better understood that a victim's accommodations to trauma sustains masochistic defenses in which victims protect their torturers (Cohen, 1953; Gyomroi, 1961).

At age 5, my second patient, Virgil, begrudgingly consented to see me, apparently to escape kindergarten where he was so consistently lonely, miserable and angry. He was certain that he had been sent to me because he was naughty, which was partly true, and he boasted that his classmates had voted him the most likely to succeed in reaching the reformatory. As I was to learn later, his mother had declared herself white when in elementary school and my intrusion into Virgil's life had awakened old wounds and illusions that contributed to her readiness to have me see him.

Hospitalized for an attempted suicide prior to her pregnancy with Virgil, his mother had dropped out of both school and church at age seventeen when he was born. During his first year, she was hospitalized for a second suicide attempt occasioned by a fight with Virgil's distant and un-supportive father, a professional athlete. Since both Virgil's mother and grandmother worked, multiple mothering extended to the neighbors. Virgil's stoicism and defenses against affects were tested by hospitalizations at age two and a half for surgical correction of his umbilical hernia (which he called his mouth) and again at age four when he was given a general anesthesia for extraction of badly decayed teeth that he refuse to brush. Virgil was proud that he was tough, that he never cried with physical pain or with solitude, as when he had been hospitalized.

Like Naomi, Virgil did not share family secrets with his teachers, or initially with me. Virgil's grandfather, the only resident male in his house, had been retired with a disability pension. He was fearful and rejecting of medical care though suffering with a severe heart condition (from which he died while Virgil was in treatment). A chronic alcoholic who abused and terrorized the household in his drunken rages, the grandfather was otherwise apathetic, withdrawn and passive when sober. Virgil's grandmother was uneducated, articulate, powerful in her convictions and affections, and the mainstay of the household. Virgil's mother, narcissistic, attractive and often *most* provocative in her attire, was employed in a respectable day-time position. While Virgil's father visited perhaps twice a year, the boy knew that his father visited Virgil's uncle (his father's brother) every week—in prison, where he was serving a life sentence for murder.

Virgil was a handsome, unusually well dressed child. His manner made him the more striking since he appeared composed, controlled and a bit autocratic and condescending. At the time when his mother (unknown to me) was arrested for prostitution, Virgil was ever more restless at school and resistant to coming for his appointments. His previous, exemplary behavior in therapy then began to change, as when Virgil insisted that he wanted to leave my office yet faced the wall mutely, with tears welling gradually, then pouring down his face. In a succession of such appointments, muffled sobs would wrack the child's body as his tears flowed. Protesting on a particular day that he *would* go, that he *would not be stopped* from leaving, Virgil crawled under my couch, and in silence kicked the floor in fury. At the end of his appointment time, still insisting that he wanted to go, Virgil refused to come out from under the couch. When I gently but surely pulled him out, picked him up and carried him downstairs, he paradoxically smiled as he continued to struggle in silent fury to stay. The next week Virgil introduced me to the rage his school had been unwilling to accommodate.

Early in that hour, Virgil insisted (again) that he *would* leave and return home, on a non-school day. I had variously, previously understood and wondered with Virgil if 1) his anger was his way of controlling the adults he cared for and feared; or 2) his way of conveying the enormity of his pain that seemed impossible to put into mere words; or 3) his need to initiate and control a physical distance, out of his fear that his anger would drive his mother/me to leave him; or 4) a passive into active defense in which he insisted on going so as to avoid the pain he felt when I said it was time to go, or 5) more probably, all of the above.

Since my secretary was not there to escort Virgil home, across two streets, I advised that he should wait while we located her. Virgil began with a sob, a cry and then a piercing, continuous scream that engulfed the department's annex, bringing colleagues and their patients into the hall. Without a break in volume, Virgil began to stomp, to swing his arms wildly, then to spit and kick at me. As the boy's kicks landed on the bookcase and his spit extended, I agreed that he should leave without delay. At that point, he resisted going as I carried him downstairs while he screamed without respite—but made no further attempt to hit or kick me.

At the bottom of the stairs, Virgil first kicked the door furiously and then a metal water fountain before he blasted out the front door. Fearing his judgment was impaired relative to street traffic, I followed Virgil and started to stop him. Then sensing the futility of

physical intervention, I followed Virgil as he half ran toward the alley at the rear of the office. There, Virgil screamed invectives and threw stones towards me from a distance. He ran down the alley, away from home, and disappeared from sight leaving me most worried. I returned to the front of the building where I sat perplexed and troubled.

Virgil reappeared at the end of the block, walking up the street carrying a massive stick that he swung with savage enthusiasm. He would pause, look towards me, pound the sidewalk with his club, and then advance another fifteen or twenty feet. Then Virgil crossed the main boulevard and continued his defiant (perhaps triumphant) march up the other side of the street, past his school, while keeping me in visual contact. A block distant, Virgil recrossed the boulevard and returned in my direction without his club. Approximately one hundred feet distant, and across another side street, he began walking backward, crossing that street (still backwards) as he moved to the outer edge of my office building where he ducked around the corner and disappeared again. Peering over a wall as he drew ever closer, Virgil then made tentative visual overtures.

Virgil's appointment time officially ended at that moment, and I called to him that it was time to go home. Virgil, most quietly, benignly, and with an angelic, tired smile ran to me and reached for my hand. His reversal of affect stunned me. Thoroughly wrung out and doubting that therapy could possibly continue thereafter, I advised Virgil that I would personally walk him home (two streets distant). Virgil walked quietly, his hand grasping mine as he murmured, "I've been very bad; I won't be able to see you anymore?" I replied that he had certainly been furious and I had certainly been worried about him. I asked if perhaps this had been his test to find out whether I could tolerate his fear and fury as we tried to understand him.

Virgil's overt anger masked what otherwise might have been more obvious, namely, that he lived miserably, fearfully and counterphobicly. His defenses against unconscious rage were obscured by counterphobic anger—that Virgil all to readily demonstrated. His mother, who thought that it was only a matter of time until Virgil joined his uncle, scoffed: "You're out of your f. . . head! You think my kid is afraid [defensive] about anger?" Since the Cardozo area always harbored quite extraordinary dangers, any fear Virgil evidenced his mother attributed to the realities of the street.

In his second year of analysis, as we began to explore some of Virgil's traumatophilic defenses, he tenuously revealed the regressive,

super ego type of plea bargain that left him so defensive and despairing of himself. Virgil was miserably ashamed of his feminine/transvestite obsessions, which he began to reveal in the context of his covertly hostile competitiveness with the girl patient who preceded him (Naomi). Virgil introduced small female dolls that he brought from home. In various animations, the mother-doll was preoccupied with cuddling her two daughters, and I was variously the mother or a daughter, and Virgil more consistently a daughter. Much later he introduced stick-drawings of two boys fighting, one of whom turned into a girl with a long sword with blood on it. Virgil introduced nuances into this "game" by suggesting that I should call him *Mrs.* Virgil. Later and more openly yet, he spoke (in fantasy) of his mini-dresses—as when he put one on, pretending to be a girl while his friend put on a wino's clothes, and the two had danced together in the street. In this context, Virgil elaborated his sense that his badly repaired umbilicus was not only a "mouth" but his "cunt". And I attempted to understand with him that his miserable abuse of his mouth might have additional, tortured meaning. Virgil became more ready to explore his confessed (nominal) bi-sexuality when I wondered with him if he might find it safer to confess to passive, feminine longings (that left him shamed) than to acknowledge his fury and rage (with abandonment) that might take him to the penitentiary with his uncle.

As Virgil's passive, regressive defenses were emerging in treatment, his grandmother concluded that my indentureship had ended and she began to provide more basic information. Virgil's mother was a heroin addict and had been a user since her son was three. She was out at all hours of the night, and often "out" when she was at home. Her self devaluation and continuing potential for suicide was never more clear than on her precipitation of her temporary imprisonment—which Virgil learned through the taunting of older street kids at age six! Overdosed while prostituting (that supplied her income for heroine), a cab driver discovered her lying comatose on the street, severely beaten with her clothes baldly torn.

Virgil's all too real miseries included his father's indifference, his grandfather's and mother's drunken parties at home, his mother's frightening absences and depressed moods, her unavailability when on drugs and physical assaults by older boys who punished Virgil for being "uppity". Virgil was only seven when he discovered his mother "mainlining" with a hypodermic. The cruelness of reality, predictably, pathologically exacerbated Virgil's paranoic defense organization. Unconscious, defensive externalization of Virgil's rage distorted

and intensified his perception of the dangers of his all too malevolent real world, which was already bad enough. Defensively depleted and an inadvertent victim of passive, feminine illusions, Virgil was like a young marine who needed to prove his masculinity and imperviousness to fear. Precipitating storms, he boasted their creation and rode them imperiously into his private misery (Fenichel, 1945). It was not difficult to understand Virgil's profound ambivalence with my compassion and emotional availability, or his certainty of the transience and tenuousness of safety or comfort.

The Ghettoization of Sexual Ambivalence: The urban black ghetto has a large measure of autonomy and lacks neither culture nor social structure (Liebow, 1967; Hannerz, 1969) though the former may not be palatable to white critics or the later viable for the black family. The cultural shared values of the ghetto are imperiously instinctualized and destructive to the mental health of its residents. The violence and sexuality of the streets, bitter as these may be, are still not as tragic as the chronic over-exposures endured by children within their own homes. Simultaneously escaping from family excesses, children pull each other into the streets in precocious rebellion from adults.

The Carnegie Foundation's extraordinary search and eventual selection of Norway's Gunnar Myrdal in the early 1940s initiated a scientific assault on the arrogance of American racism. In his *American Dilemma*, Myrdal (1944) concluded that the bizarreness of U.S. slave and post slavery years contributed such cultural and legal sanctions of informality that public records of both marriage and divorce were useless as indices of the integrity or disintegration of black families. If one were to assess the relevance of the past on the present, or the migrations North and West on black family stability, sociologists needed an alternative index. Myrdal concluded that illegitimacy rates provided the best approximation.

When I began Naomi's therapy, the illegitimacy rate in Washington D.C. was 30%; it now exceeds 50%. As a different and new index, Rainwater in 1966 estimated that 60% of all ghetto children were raised in one-parent families for part of their minority; that figure, depending on the sociological parameters used to define geographical areas, probably now exceeds 75%.

While sexual, biological identity begins with genetics and anatomy, both culture and family psychopathology can pathologically subvert both. The gender illusions of borderline trans-sexual psychopathology (of being trapped in the body of the opposite sex) affords a caricature

of the gender problems that psychoneurotic defenses contributed to Virgil in particular, and Naomi more generally.

Psychoanalytic microscopy can and should supplement sociological and anthropological macroscopic research procedures by the detailed exploration of how parental, cultural values are psychologically sustained or perniciously distorted and conveyed to any one child (within our discriminating society). Clinical experience demonstrates the subtle but dynamically tragic processes through which the biases of a dominant white culture become a derogatory, self-fulfilling prophecy when traumatized, ghettoized parents unwittingly or unwisely employ extortion to establish a child's guilt and self recrimination (Rainwater, 1966; Butts, 1969; Meers, 1974). "Identification with the aggressor" always entails unconscious childhood submission to archaic fears and standards the child then internalized. We describe that phenomenon as a super ego development, and when it is traumatic the clinical consequences include chronic self deprecation and submissive, masochistic illusions of inferiority.

However damaging the general psychological consequence of being born black in a dominantly, often covertly hostile white culture, the primary vehicle for the turning of aggression on oneself begins in infancy, at home in the conflicts of sexual identity. The inevitable guilt and shame of childhood misbehavior (in any culture) are pathologically compounded when a child's superego development is traumatically precipitated. Such youngsters are then victims of their own precocious, Old Testament condemnation of drives, motives and dignity.

The identity of the unborn begins in the minds of their parents who inevitably program their babies' value from parental strengths or wounded defensiveness. Ghetto mothers, regrettably, are too often depressed, guilt-ridden and traumatized (and I have yet to meet one who is a content, lusty sensualist). They evidence severe, recriminating consciences that correspond to exposures to fundamentalist religiosity. That they continue to seek male companionship, as indeed they do, testifies to the awesome burden of loneliness of the one-parent family—and perhaps also to maternal masochism, the pain that permits sexual fulfillment. Given the chronic pain of heterosexual relationships, it is clinically evocative (from middle class perspective) that ghetto mothers with multiple pregnancies and abandonments do *not* seek solace from other females, as in lesbian marriages. Ghetto mothers appear homophobic in their derogation of defensive, regressive effeminacy in their young sons. It might theoretically be argued

that homophobic attitudes of ghetto mothers derive from unconscious, counterphobic defenses against the attraction of female protection and nurture. Clinical experience with both Mrs. N and Naomi would demonstrate the fictitious character of middle class theory.

From less than benign histories of sexual experience, ghetto mothers' fears and recriminations are evident in their projections and narcissistic identifications with their babies. *Man* is a common maternal reference to infant sons. Half proud, mothers joke sardonically about the early evidence they see of their boy babies' stubbornness, aggressiveness, vindictiveness. In their expectations and attributions of aggressive qualities, mothers provoke self-fulfilling, hostile prophecies. In that context, it is very evident that the depressed, traumatized, passively defended black female is alternatively capable of explosive wrath, not infrequently evident in child abuse or, indeed, homicidal violence.

"Joning," the "dozens" (Abrahams, 1962), provides the opportunity to consider distinctions between developmental disasters, between oedipal and more elemental, infantile defenses. The object of joning is to confirm masculinity in competitive group confrontations in which rhyming, sexual insults test the imperturbability of the contestants. Denigrations are characteristically of mothers and sisters, particularly their purported sexual promiscuity, undesirability, and occasional bulldager (lesbian) qualities (Hannerz, 1969). Such shared derogatory testing demonstrates a male adolescent's counterphobic denial of interest in, his protectiveness of, or disgust with maternal sexuality (in matriarchal, typically over instinctualized families). It also reflects adolescent anger and emerging contempt that will mature as incipient rage in adult male abuse of the women on whom they project their own promiscuous inconstancy.

Maternal depressions and physical separations imperil the symbiotic, psychological structuralization of their infants' primal ego functions. Infants do not survive without some minimal human nurture. Psychoanalytic efforts to comprehend the evolutionary twin-ship, of ego structuralization and object differentiation, include Klein's notions of infantile paranoia, Spitz's conceptions of anaclytic depression, Mahler's reformulations of self and object individuation and Kohut's formulations on narcissistic pathology. Which is to say that psychoanalytic theorists should be profoundly interested in the ghetto's cultural test-tube that racism has incidentally and miserably presented.

"Mother's Day" is a bad ghetto joke, the day of the month that unattached men exploit the lonely ghetto mother in the disbursement of

her welfare check. Men are *not* absent from the matrifocal home, but they are too often disabled, alcoholic, addicted, depressed and angry. Small children, captive in their mother's crowded apartments, are frightened spectators of adult passions, both sensual and sadistic.

Professional notions of contraceptive helpfulness appear all too psychologically naive. Condoms/rubbers and abortion are quite available on demand in the ghetto, yet the illegitimacy rate extends ever more. From male perspective, to "knock-up" a girlfriend is proof of manhood, which (not incidentally), defensively establishes male invulnerability to emotional attachment to the women they impregnate. To "ride bareback", without a condom, is a male version of "Vatican roulette" in which the fate of the woman is hardly irrelevant to her subsequent abandonment and victimization. Which is consistent with Liebow's conclusion (1967, pp. 145-153) that condoms are used (particularly) with women a man does *not* like.

"The street" is alive and feared in its defiance of maternal control of friendships, delinquency and sexuality. With conspiratorial anonymity, children recruit each other into an early independence from their homes. The attraction of street peer groups appears to derive from the child's need for psychological distance from the intimate painfulness of home and from the relief from guilt provided by group-sustained regressions in which conscience is externalized and the youngsters become morally counterphobic.

The ghetto child's fear of his own unconscious rage contributes to paranoic projections; but in the instinctual, hostile excesses of the ghetto, his paranoid fears are obscured by a reality that approximates a middle-class neurotic's worst nightmares. In this context, the streets' peer groups affirm and escalate disillusionment with marriage and constancy. Mainstream notions, as popularized by Bill Cosby, are tantalizing and illusory. The ghetto couple suffers both self-doubt and the eroding humor of friends. The basic defensiveness of the street remains predominantly corrosive: "What did you expect? All men/women are dogs/bitches!" and there is scant comfort in the reassurance that infidelity is inevitable and permanence illusory.

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